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REPORT OF THE SUB-COMMITTEE
ON SPECIAL SERVICES IN HOSPITALS

GUIDELINES FOR ESTABLISHING STANDARDS
FOR SPECIAL SERVICES IN HOSPITALS

ADDICTION SERVICES IN HOSPITALS

Health Services Directorate
Health Services and Promotion Branch

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IMPORTANT

The information contained in these Guidelines was current at the time of publication. When using the Guidelines it should be remembered that certain aspects of the delivery of health care and health technology are changing rapidly. Should you identify any out-of-date material in the text, please inform:

Mr. D.F. Moffatt,
Chairman, Sub-Committee on Special
Services in Hospitals,
Health Services Directorate,
Health Services and Promotion Branch,
Department of National Health and Welfare,
Ottawa, Ontario.
K1A 1B4

Further copies of these Guidelines in both official languages can be obtained from the above person.

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GENERAL INTRODUCTION

BACKGROUND

Advances in health technology and changes in the planning and delivery of health care have contributed to an increasing demand for specialized care facilities and services in hospitals. A dramatic rise in the number of intensive and specialized care facilities and services in hospitals has occurred in recent decades due to rapid technological development in electronics and automation, and as a result of new approaches to patient care. These changes have produced demands for physical facilities, specialized equipment and highly trained health manpower. Because of this, there is a continuing need for guidelines for standards to assist those involved in planning, organizing and operating special care services in hospitals.

MANDATE

In 1972, health authorities in Canada recognized the need for guidance in this area, and the Federal-Provincial Advisory Committee on Health Insurance commissioned the Working Group on Special Services in Hospitals to create guidelines for standards to provide a reliable definition of requirements for a number of special care facilities and services.

Guidelines were developed by the Working Group for 14 units and services, and in 1975, these were published under the title, Guidelines for Special Care Units in Hospitals. This volume was widely distributed to provincial health and hospital authorities, and to national and international health organizations, and has been adopted by many as a guide.

The continuing development of existing and new health technologies, together with changes occurring in the pattern of health care delivery, gave impetus

to the updating of the 1975 guidelines, and to the development of guidelines in additional areas. In May 1982, the Federal-Provincial Advisory Committee on Institutional and Medical Services granted the Working Group continuing status as a sub-committee of the Advisory Committee. The name of the Working Group was therefore changed to the Sub-Committee on the Special Services in Hospitals. A complete list of Guidelines published or being prepared by the Sub-Committee is found in Appendix III.

METHODOLOGY

The Guidelines published in 1975 were developed on the principle of a consensus of information, knowledge, experience and expert opion obtained from appropriate organizations and individuals throughout Canada. They were based, where possible, on guidelines developed in Canada, and from authoritative sources in other countries. This approach has been generally acceptable to government and hospital authorities and the health professions.

The present Guidelines were prepared on a similar basis. On this occasion, in addition to input from provincial authorities, the expert opion of health professionals was obtained.

SUGGESTED PURPOSE OF THE GUIDELINES

The Guidelines should not be regarded as rigid standards. Their application may vary throughout Canada, and it is the prerogative of each province to accept, modify or reject the Guidelines according to provincial priorities.

The purpose of the Guidelines is to provide a definition of requirements for a number of special care facilities and services. They are not intended to provide standards for clinical practice.

Where development of a unit or service is under consideration, the Guidelines will assist planners and government health authorities in determining the need for such a unit or service and in assessing the total potential impact of a new unit on existing and projected services, both at the local and regional levels. Deficiencies in existing services can be identified, and in some cases these can be corrected without the need to develop a new unit or service.

Where a unit or service already exists in a hospital, the Guidelines will help to identify problem areas related to administration, personnel, equipment, and physical facilities. They will help to determine necessary remedial action and to set priorities for corrective measures on the basis of clinical need, fiscal realities, and the degree to which a deficiency in the physical facilities impedes adequate functioning of the unit.

FUTURE REVISIONS

Because of the rapidly changing nature of health care, the Guidelines will require regular revision. It is planned to maintain the Sub-Committee to carry out this function.

It should be noted that the Guidelines in this particular volume replace two previous Guidelines volumes, Narcotic Addiction Treatment Unit and Detoxification Unit.

ACKNOWLEDGMENTS

The Sub-Committee acknowledges with sincere appreciation the immense amount of work undertaken and time given by practising health professionals in Canada in providing detailed written information and guidance in the preparation of these Guidelines. In addition, we wish to thank the many others who, in any way, contributed advice and information to this endeavour.

LIST OF PARTICIPANTS

The membership of the Sub-Committee on Special Services in Hospitals, responsible for the preparation of the new and updated Guidelines, is as follows:

Mr. Donald F. Moffatt, Chairman
Director
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Mr. Derek J. Beckley
Director
Program Planning Branch
Hospital Services
Alberta Hospitals and Medical Care
EDMONTON, Alberta

Mrs. Primrose Bishop
Nursing Consultant
Hospital Services Division
Department of Health
ST. JOHN'S, Newfoundland

Dr. Maurice Héon
Professeur et directeur
Département de Neurochirurgie de la Faculté de médecine de Sherbrooke
Centre Hospitalier de l'Université de Sherbrooke
SHERBROOKE, Québec

Dr. Gordon A. Judge
Medical Director
Toronto Western Hospital
TORONTO, Ontario

Mrs. Phyllis MacDonald
Standards Officer
Urban Health Facilities Division
Manitoba Health Services Commission
WINNIPEG, Manitoba

Mr. David L. Martin
Consultant in Health Technology
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Dr. Hans H. Rubarth
Consultant, Health Administration
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Dr. Robert Seaver
Senior Medical Consultant
Personal Health Division
Program Advisory Branch
Ministry of Health
TORONTO, Ontario

Secretariat

Mrs. Janet Stow
Project Manager
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

This guideline was produced with the assistance of the Federal-Provincial Sub-Committee on Alcohol and Other Drug Problems, whose contribution is here gratefully acknowledged.

The members of the Working-Group on Addiction Services are as follows:

Dr. Gordon A. Judge, Chairman
Medical Director
Toronto Western Hospital
TORONTO, Ontario

Mrs. Martha Birrell
Unit Supervisor
Emergency Department and Detoxification Unit
Royal Alexandra Hospital
EDMONTON, Alberta

Mr. Marvin Burke
Executive Director
Nova Scotia Commission
on Drug Dependency
HALIFAX, Nova Scotia

Dr. Guy Chouinard
Associate Professor of Psychiatry
Allan Memorial Institute
Royal Victoria Hospital
McGill University
and Hôpital Louis-H. Lafontaine
MONTREAL, Québec

Dr. Dmytro Cipywnyk
Medical Director
Saskatchewan Alcoholism Commission
SASKATOON, Saskatchewan

Mr. Pieter de Groot
Director
Edmonton Region
Alcohol and Drug Addiction Commission
EDMONTON, Alberta

Dr. Gordon Johnson
Chairman
Department of Pharmacology
University of Saskatchewan
SASKATOON, Saskatchewan

Mr. Garth Martin
Head
Sociobehavioural Treatment Services
Clinical Institute
Addiction Research Foundation
TORONTO, Ontario

Coordinator

Miss Marjorie Carroll
Nursing Consultant
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Additional Contributors

The following experts in the field are gratefully acknowledged for the contributions which they provided:

Dr. T. Da Silva
Chief
Central Nervous System Division
Bureau of Human Prescription Drugs
Health Protection Branch
Department of National Health and Welfare
OTTAWA, Ontario

Mr. T. Franklin
Head
Counselling Unit
Drug Therapy Program
Clinical Institute
Addiction Research Foundation
TORONTO, Ontario

Dr. J.A.L. Gilbert
Geographic Professor of Medicine
Royal Alexandra Hospital
EDMONTON, Alberta

Mr. H.J. Schankula
Director
Education Resources Division
Addiction Research Foundation
TORONTO, Ontario

Note

This volume replaces Detoxication Unit and Narcotic Addiction Treatment Unit Guidelines.

ADDICTION SERVICES

P R E A M B L E

Background

The history of mankind provides evidence of alcohol and other drug use throughout the ages, with alcohol being the most commonly used and abused mind altering drug in western society. The knowledge of those familiar with the use of various chemicals is supported by very general and often subjective information. There are a wide variety of opinions among workers in these areas based on their own experiences. There is a lack of hard data to support much of the following discussion in this preamble which many workers in this field, nonetheless, believe to be near the truth and, therefore, useful in gaining a general feel for the need and type of service discussed.

Currently there are increasing reports of clinical findings to suggest that negative effects (e.g., psychotic behaviour) of more than occasional marijuana usage are more severe than previously suspected. Chemical substance usage, morever, may be laden with both accurate and inaccurate information and is often associated with a great deal of mythology. Societal approval and disapproval of chemical substance abuse has varied widely, and still does vary, with sanctions running the gamut from punishment to disregard.

Changing social conditions in western society during the 1960s saw a greatly increased use of drugs other than alcohol, a trend which peaked during the 1970s. Public expressions of concern highlighted the use of prescription drugs by adults as well as the non medical use of such drugs. The illegal use of drugs such as marijuana, L.S.D. (acid), narcotics, cocaine, amphetamines (speed) and other psychoactive drugs, mainly by young people, also caused and still causes much concern. Drug subcultures emerged. "Drug trafficking" and "street scene" became household words as a result of intense and wide ranging debates in the media and elsewhere about the consequences of drug abuse.

To combat the negative consequences of the abuse of both legal and illegal drugs, the federal government, indirectly, and the provincial/territorial goverments, mainly through their alcoholism and drug dependency commissions/foundations, turned their attention to the emerging "drug problem". Especially in larger cities, innovative intervention programs were developed, aimed at preventing and treating these new substance abuses. Street workers, youth counsellors and others focused on these new problems. Traditional alcoholism treatment services and other caring agents struggled to find effective methods of helping the new teenage and adult clients with their "drug problem".

During the 1970s, Canadians grew accustomed to the new reality of illegal drug use and the non medical use of prescription drugs. The professional organizations, chiefly the alcoholism and drug dependency commissions/foundations, providing addiction services, found that alcohol misuse was the major substance abuse. A smaller percentage of clients evidenced "poly drug" use problems, usually involving alcohol, prescription drugs and/or illicit drugs. A small percentage of clients abused drugs other than alcohol only.

Current Situation

Chemical substance abuse has become more readily accepted as a treatable health problem. As a result, there has been an expansion of patient caseloads as persons of varying socioeconomic strata present themselves for treatment and rehabilitation. There is a percentage of unidentified serious drinking problems among patients admitted to hospital for other reasons. The use of alcohol specifically has become very common among the young and is on the increase among people in Canada in general. New target groups are being identified which require different approaches to treatment.

The increased problems associated with cannabis and minor tranquillizer use have found their way into treatment centres. Additionally, there is still a flow

of various street drugs, such as the opiates and the new "look alike" drugs now on the streets across the country.

Any effort to provide an accurate response to the varying manifestations of alcohol and drug abuse must be influenced by comprehensive assessment of both the individual patient needs and community substance abuse problems. Such assessment should be seen as part of an ongoing process.

As far as the individual patient is concerned, assessment must link behaviour, personal history, medical history, drug use and interpersonal relationships to develop a clear profile of the patient's past and present state and his future potential and course of treatment.

For planning purposes, it is essential to create an index of substance abuse problems, taking into consideration as many sources of information as are available (e.g., existing provincial commissions/ foundations, poison control centres, emergency departments, hospital patient data). It is important to emphasize that the pattern of drug usage will vary from time to time and from community to community.

Present System

At this point in time in Canada, there exists a network of treatment and rehabilitation services funded primarily at the provincial/territorial level, located in all ten provinces and the two territories, and delivered primarily through provincial/territorial alcoholism and drug dependency commissions/foundations. Philosophically, provinces and territories accept the need for comprehensive programs and attempt to provide a broad range of services with emphasis on decentralization to the local level in most circumstances. Education and prevention is also provided through the offices of the various commissions/foundations with assistance from the Health Promotion Directorate of Health and Welfare Canada. Emphasis is placed on providing information

in schools, to families, through employee assistance programs and through community groups. Focus for these programs is on attitude change and the development of personal coping skills. Similar interest must be developed within the hospital community.

In treatment and rehabilitation, most provincial models include detoxification, assessment, treatment and aftercare involving in-patient, out-patient and day-patient settings. Medical complications and emergencies are usually referred to general hospitals.

Within any health care delivery system there is a need for a broad range of services to meet the different needs of the presenting patient. The continuum of care which includes access to acute as well as aftercare services, both on an in-patient and out-patient basis, is essential. While the acute stage of treatment may often be perceived as the most critical, success can only be gauged through patient involvement in continuing care. Aftercare, therefore, is a crucial aspect of treatment and rehabilitation and should include involvement of the family and may include self-help groups, other community resources and supportive persons.

This manual will offer guidelines for the planning of such services. While the guidelines are written for use by policy makers, general hospital planners and administrators, it should be noted that the development of addiction services must be compatible with the locally existing provincial/territorial addiction services and hospital planned programs must establish and maintain consultation and cooperation with them.

INTRODUCTION

Many of the social and economic changes in Canada have contributed to the need for addiction services. An increasing level of alcohol consumption and other drug use has resulted in increased alcohol/drug abuse induced behaviour problems. This, in turn, has created pressure on the existing services to provide care. The development of new concepts subsequently led to the establishment of specialized addiction services as a constructive response to the demand.

OVERVIEW OF SERVICES

The effective management of alcoholism and other drug induced problems requires an individualized approach, a variety of professional disciplines and a wide range of therapeutic modalities and facilities. In some parts of the country concerted action has been taken to implement the required programs. The key to this was the recognition that a comprehensive approach was necessary, involving the provision of a broad continuum of services provided by a variety of community resources which should include the following:

1. Detoxification Services

2. Residential (In-Patient) Treatment Services

3. Out-Patient Services

4. Aftercare Services

5. Education and Health Promotion Services

The following table illustrates the range of addiction services that form a continuum of care.

RANGE OF ADDICTION SERVICES FORMING A CONTINUUM OF CARE

CONTINUUM OF SERVICES

Service	Patient Source
Detoxification	. Emergency Department . Community
Residential (In-Patient) Treatment	. Identification of in-patient with drug or alcohol problem . Admission with drug or alcohol problem not requiring detoxification . Completed detoxification
Out-Patient	. Continuing service from detoxification and residential (in-patient) treatment . Direct referral (self or by others)
Aftercare (Various sources and types)	. All of the above
Education and Health Promotion	

1. Detoxification Services

Detoxification is defined as a process by which a person achieves a level of acceptable physical, psychological and social functioning following a toxic alcoholic or other drug induced state.

A program for detoxification must involve consideration of the following:

(a) A detoxification service is only the initial phase of a continuum of care. To be effective, detoxication services must be closely linked to subsequent active treatment and aftercare services to deal with excessive drinking/drug abuse and related problems. It is important to coordinate detoxification and subsequent treatment in the same facility or through appropriate referrals.

(b) Many types of detoxification services, which may be hospital or community-based, may be developed. They should be supported by existing services (e.g., psychiatric assessment, medical coverage). In the process of their development, consideration should be given to the most cost effective method of supplying the service.

(c) All detoxification patients must have access to general hospital services even though only a small proportion will ever require acute in-patient services.

A detoxification unit has several roles:

(a) To provide a protective setting in which intoxicated persons may be safely withdrawn from the effects of acute intoxication. This may require:

- medication
- psychosocial support
- physical observation

- rest
- attention to personal hygiene
- attention to nutritional needs
- referrals

(b) To motivate the patient for further treatment and ongoing care. It should be noted that a certain number of alcoholic patients are unreceptive to any treatment program, even after repeated admissions. This fact does not negate the value of detoxification services for this group of patients. In cases of repeated admissions, innovative motivation techniques should be considered.

(c) May be a regional resource centre offering educational and consultative services to other agencies in the community.

(d) To identify gaps in the existing range of referral options.

2. Residential (In-Patient) Treatment Services

These services include early identification, assessment and treatment involving a multidisciplinary approach.

Potential recipients of in-patient treatment services include patients who have:

- been in detoxification services or units;
- been admitted for a medical or psychiatric problem with subsequent diagnosis as having an alcohol/ drug abuse problem;
- been referred to the hospital primarily for an alcoholism/drug abuse problem or a medical complication of these.

The professional staff of the treatment unit will have varying levels of knowledge and attitudes with regard to treating the addicted person.

(Refer to Out-Patient Services for the use of Methadone in the treatment of opiate dependency).

The multifaceted problem of alcoholism and drug abuse often requires consultation with other services, including medical, nursing, psychological, social services, chaplaincy, courts, law enforcement officers, self-help groups and employers.

Educating hospital staff about identification of addiction related problems, management of such problems and effective discharge planning (including referral) is an important hospital function.

Early identification of alcohol addiction should be encouraged within the hospital (e.g., laboratory markers, questionnaires) with specific emphasis on high risk groups (e.g., psychiatry, gastroenterology, obstetrics).

3. Out-Patient Services

Potential recipients of these services are:

(a) patients who have been in a detoxification service or unit;

(b) patients who have received in-patient treatment services and residential (in-patient) treatment services;

(c) patients who have been otherwise referred for a chemical dependency problem.

The out-patient service may be under the jurisdiction of the hospital or other organizational entity.

Some hospitals may wish to establish clinics or units for the treatment of opiate dependence in which methadone is to be prescribed as part of

the treatment regimen. The prescription of methadone in the treatment of opiate dependence is subject to guidelines established by the Central Nervous System Division, Bureau of Human Prescription Drugs, Health Protection Branch of Health and Welfare Canada, Ottawa, Ontario, K1A 1B8.

Physicians wishing to prescribe methadone for opiate dependence treatment must make application for authorization to the above address of the Health Protection Branch, identifying treatment centre affiliation, if any.

Hospitals wishing to establish programs involving the prescription of methadone for the treatment of opiate dependence must submit protocols to the above address of the Health Protection Branch for approval.

4. Aftercare Services

These services are those that are provided on release from the treatment program, or in assistance to the treatment program, for the support of the individual in the community by:

- self help groups
- ongoing supportive counselling
- legal aid
- vocational counselling

Feedback to the referral source should be provided by those services and agencies providing aftercare to ensure that the continuum of care is maintained. It is imperative that appropriate reporting procedures that maintain confidentiality be established to ensure the feedback process.

5. Education and Health Promotion Services

Hospitals throughout Canada are becoming more actively involved in health promotion, education and prevention programming. This trend reflects a growing acceptance, by hospital boards,

administrators and clinicians, of the view that hospitals may offer these types of services. Drug and alcoholism concerns lend themselves particularly to potential benefits from the education and health promotion activities of such community health centres. To be effective in offering these programs, hospitals must coordinate their services with other community resources in the human service system (e.g., Provincial/Territorial Commissions/Foundations).

Hospitals which fulfill an enlarged mandate with these services, and which plan for and provide an active program of health promotion and education, will benefit from being able to work with a more enlightened public, more knowledgeable and empathetic professionals and a patient population appropriately referred and discharged into a better functioning system of community health care.

The need or desire for new knowledge or education underlies most requests for information, consultation, talks or lectures. Education is one of the primary modes of achieving primary prevention. Primary prevention has been defined as encompassing activities directed towards high risk groups and groups about which no assumption of risk is entertained. Its intent is to promote health and prevent illness. Health promotion, protection and resource development strategies are directed toward influencing the agent, host, environment and their interactions.

In making decisions about the kind of consultation and education services that should be developed and provided, it is important to identify the target groups:

- in-patients, out-patients and their families
- the community

Such services to community groups consist primarily of providing consultation and education to:

- enhance the ability of such individuals and agencies to promote healthy lifestyles with respect to the use of alcohol and other drugs;
- enhance skills relating to early case identification, assessment, treatment and aftercare.

Hospitals are encouraged to develop written plans for the provision of addiction related consultation and education services to patients and their families and to the community in conjunction with the provincial/territorial commission/foundations.

Such written plans, updated as necessary, will:

- enhance the effective use of hospital resources;
- ensure that the hospitals' services are integrated into a system of prevention, treatment and rehabilitation which may already exist within the community.

Written plans for the service should include:

1. philosophy, goals and objectives
2. assessment and treatment
3. administrative organization
4. staff responsibilities
5. policies and procedures
6. method of evaluation
7. sources of funding
8. liaison with the community

There may be education programs for:

(a) the health care community (e.g., students, hospital staff, board members, volunteers);

(b) the general community;

(c) the support service community.

The following are examples of topics that could be addressed to the above communities. The specific topic and the depth involved depends on the community being addressed;

- adverse interactions of alcohol with other drugs;
- cirrhosis of the liver - diagnosis and management of complications;
- alcohol absorption and metabolism;
- professionals at risk (physicians, pharmacists, nurses, etc.);
- early identification - motivating - educating;
- alcohol and its effect on emotion;
- nutrition and the alcoholic;
- detection and diagnosis of alcoholism and criteria for hospital admission;
- medical aspects of alcoholism;
- diseases secondary to alcoholism;
- treatment of acute alcoholism in hospitals;
- management of mentally disturbed alcoholic patients;
- drug therapy of hospitalized patients in alcohol withdrawal.

GUIDELINES

The guidelines are presented in the awareness that it is desirable to have maximum utilization of community resources, expertise and support.

I DETOXIFICATION UNIT

The unit described in the following guidelines may be a unit within a hospital or a separate unit that may be within a hospital system.

1. PATIENT LOAD

Utilization data from existing detoxification units of varying types, in a number of provinces, indicate an annual admission range of 2.5 to 8.5 admissions per 1000 population (1981/82 data).

The average length of stay per admission to the detoxification unit is in the range of 2 to 10 days, depending on policy, practice, patient population, and substance ingested.

2. BED REQUIREMENTS AND RECOMMENDED DISTRIBUTION OF UNITS

The required number of beds varies according to urban-rural and other demographic factors and in situations where a unit is directly attached to a general hospital.

The male to female bed ratio is generally in the range of 2:1 to 8:1 (1981/82 data). This probably depends on socioeconomic and demographic factors. The type of facility available may dictate whether units are mixed or segregated.

Experience suggests that the optimum size of a detoxification unit, not geographically attached to an acute care hospital, is in the range of 15 to 20 beds depending on local incidence of alcoholism, the socioeconomic status of the population and regional demography. Hospital attached units may be smaller depending upon the local situation.

Bed requirements per unit of population also depend upon:

- substance involved
- admission policies
- treatment policies
- referral patterns
- availability of other resources and post discharge treatment programs

3. ADMINISTRATIVE POLICY, PROCEDURES AND CONTROL

3.1 Role and Objective of Unit

To provide a safe environment in which the patient can:

- receive treatment
- be detoxified
- be protected
- be motivated
- be orientated and referred to available services

3.2 Type of Patients Served

The patient may be:

- self referred
- otherwise referred

3.3 Services Provided

The following services are considered to be essential:

- safe environment during the detoxification phase
- observation for abnormalities and complications which may require medical and/or psychiatric assistance

- medication, treatment, rest, hygiene and nutritional restoration
- comprehensive assessment
- individual counselling

Depending on the length of stay and patient cooperation, the following services are desirable:

- group therapy or discussion
- family involvement
- health promotion
- referral to appropriate community agencies

3.4 Organization of Unit

The organizational structure should be defined by the governing board or equivalent and the chief executive officer, in accordance with its policies and organization.

3.4.1 Unit Management

Specific Responsibilites of Staff

(a) The Director is responsible for:

- the management and administration of the unit
- the direction and ongoing training of staff
- liaison with police, community agencies and the coordinator of the provincial detoxification programs as indicated
- liaison with community groups with regard to referrals

In large units, it may be desirable to designate a supervisor to assist in the day to day operation of the unit and supervision of the unit staff.

(b) Unit staff are responsible for:

- patient care
- patient records
- supervision of patient activities
- working with patient, relatives and referring agencies
- admission and discharge duties

(c) Medical consultation must be readily available on a prearranged basis.

(d) Coordination of educational and consultative services to other agencies in the community should take place.

3.4.2 Advisory Committee

- Membership should include the Unit Director, representatives of hospital management and local alcoholism treatment authority where applicable and other resource persons as appropriate.
- The terms of reference should be defined.
- There should be provision for consultation with appropriate hospital and medical staff.
- There should be schedules for formal meetings with minutes kept.

3.5 Policies for Operation

3.5.1 Admission must be by authority of:

- Unit Director
- Unit Supervisor
- Delegate

3.5.2 Admission decisions should be by assessment of clinical condition and diagnostic category as appropriate, based on written criteria.

3.5.3 The use of personal prescription drugs must be reviewed with the unit medical consultant on admission.

3.5.4 Written standard procedures for patient management must be established and reviewed at least annually.

3.5.5 Guidelines for average length of stay, discharge, and referral or ongoing treatment and rehabilitation should be written and applied.

3.5.6 Guidelines for seeking medical consultation based on specific routines must be written and applied (e.g., mandatory for seizures, status epilepticus, hematemesis, drug addiction or overdose and diabetes).

3.5.7 Initial and continuing educational requirements of staff should be written and applied.

3.5.8 Appropriate individual patient records must be prepared and maintained with confidentiality procedures established.

3.5.9 Equipment maintenance and occupational safety standards must be enforced. Infection control and other patient safety procedures must be established.

3.5.10 Unit objectives must be specified and continuing evaluation of the effectiveness of the unit and its staff should be carried out on a regular basis.

3.6 Procedures

Procedures for routine patient care, emergencies, health records, statistics and patient/visitor regulations must be defined and written into a procedure manual. There must be procedures established for control of smoking and other fire and safety hazards.

4. STAFF ESTABLISHMENT AND COVERAGE

There should be a Unit Director.

In large units of thirty or more beds, it may be desirable to designate a supervisor to assist in the management of the unit.

Unit staff may consist of counsellor-attendants to provide twenty-four hour, seven day coverage.

Trained volunteers may be used in appropriate situations.

There must be twenty-four hour on-call medical consultant coverage.

5. STAFF TRAINING AND QUALIFICATIONS

5.1 Initial

Director:

- ability to manage staff, coordinate patient care and develop and control budgets;
- should possess proven administrative skills;
- should have an understanding of the alcohol/drug abuse patient;

- should be able to liaise with hospital staff and community agencies;
- such abilities may be found in social workers, nurses or other persons with equivalent combinations of experience and preparation.

Unit Staff:

- ability to work with the intoxicated person;
- such abilities may be found in registered nurses or staff with other nursing qualifications or in those experienced in working with alcoholics/ drug abusers or in those felt to be suitable for on the job training, such as stable recovered persons.

Volunteers:

- where utilized, should receive initial inservice training.

5.2 Continuing

Director, Unit Staff, Volunteers;	- opportunities should be provided for upgrading of education by attendance at core knowledge programs[1] in the addictions field, refreshers courses, seminars and workshops; - audio-visual materials should be available.

1. National Planning Committee on Training, Core Knowledge in the Drug Field - A Basic Manual for Trainers, Health Promotion Directorate, Health Services and Promotion Branch, Health and Welfare Canada, 1978. (Series of 12 booklets).

6. SPECIFIC SUPPORTING DEPARTMENTS AND SERVICES

Support services of an acute hospital including:

- ambulance
- chaplaincy
- emergency
- laboratory
- medical and surgical consultation
- nutritional counselling
- pharmacy
- psychiatry
- social work

7. SPACE ALLOCATION[2]

7.1 Direct Patient Care Areas: 8.5 to 9.5 net metres squared per patient

- reception area
- admission cleanup area
- counselling and quiet room
- sleeping area
- living area/recreation/lecture

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2. Detoxification Units, Design Considerations for Specials Services in Hospitals, Health Facilities Design Division, Health Resources Directorate, Health Services and Promotion Branch, Health and Welfare Canada, 1980.

7.2 Support Areas: 3.0 to 5.0 net metres squared per patient

- kitchen
- dining (staff and patients)
- offices
- washroom bath and shower facilities (staff and patients)
- safe storage area (records, patient property, equipment and supplies)
- visitors

Total net metres squared/patient: 11.5 to 14.5.

Adjoining parking for staff and visitors.

8. EQUIPMENT

Resuscitation equipment which may be available for use by qualified personnel (certified where required) includes:

- oxygen
- cardiac and respiratory arrest equipment
- necessary drugs appropriately secured
- intravenous fluid
- suction

Residential furniture and equipment includes:

- dining room furniture
- kitchen equipment and furniture
- lounge furniture
- sleeping area furniture

- laundry services should be centralized but domestic type equipment should also be available in the unit
- safekeeping facilities for patient valuables and patient medication.

9. RELATIONSHIP TO OTHER DEPARTMENTS AND SERVICES

The unit should have ready access to:

- general and psychiatric hospital services
- community agency services

II RESIDENTIAL (IN-PATIENT) TREATMENT SERVICES

1. PATIENT LOAD, BED REQUIREMENTS AND RECOMMENDED DISTRIBUTION

A significant number of hospitalized patients may require or could benefit from such in-patient treatment services.

The length of stay per admission is contingent on the patient needs and varies widely in the recorded range from 15 to 28 days.

Bed requirements are dependent upon the patient load and the program objectives in relation to the identified community need.

Beds used by patients with alcohol or other drug related problems tend to be distributed throughout every general hospital on medical, surgical and psychiatric services and, depending on patient need, patients may be treated there or placed in a hospital program or referred to other community services.

Units specifically for residential (in-patient) treatment of these problems may be established according to identified need and provincial policy.

2. ADMINISTRATIVE POLICY, PROCEDURES AND CONTROL

2.1 Role and Objective of Service

To provide a service in which the patient may:

- receive treatment for medical problems
- be protected
- be motivated
- be oriented and referred to available services

2.2 Type of Patient Served

The patient may be:

- an in-patient identified as having an alcohol/drug abuse problem with or without a medical complication;
- a medical, surgical or psychiatric patient admitted in whom an alcohol/drug abuse problem becomes identified:
- a patient admitted for detoxification.

2.3 Services Provided

- identification of alcohol/drug abuse problem
- medical and psychosocial assessment
- development and provision of treatment plan, including discharge planning
- nursing and other health care services
- specialized alcohol/drug abuse treatment services (e.g., methadone in conjunction with provincial/territorial commissions/foundations)
- consultation and referral
- community education and health promotion

2.4 Organization of Service

If a specific unit or service for alcohol/drug abuse is established, it must have a director and the organizational structure should be defined by the governing board or equivalent in accordance with its policies and organization.

For alcohol/drug abuse treatment units or services, there must be:

(a) Supervisory personnel responsible for:

- the day to day patient treatment and care
- supervision of care providers;

(b) Medical services provided;

(c) Organization of educational and consultative sources within the hospital;

(d) Coordination of aftercare and referral services in the community.

If there is an organized unit or service, there should be provision for representation of the unit or service in hospital management. Where no unit or service exists, the hospital should make provision for the care of those patients who are identified as having alcohol/drug abuse problems.

2.5 Policies

2.5.1 Policies should be established for:

- admission
- assessment

- clinical documentation
- treatment
- rehabilitation
- discharge planning
- referral and consultation
- staff educational requirements
- evaluation of service

2.5.2 There must be policies established for control of smoking and other fire and safety hazards.

2.5.3 There may also be policies established relative to research activity.

2.6 Procedures

Procedures for patient care, emergencies, health records, statistics and patient/visitor regulations and other procedural matters should be defined and written into a procedure manual.

3. STAFF ESTABLISHMENT AND COVERAGE

There must be individuals designated and identifiable for supervisory and counselling purposes.

Nursing staff must provide twenty-four hour coverage.

There must be twenty-four hour on-call medical coverage.

Dependent upon the services offered, various disciplines and volunteers may be designated to the service or unit.

Provision for student instruction for a variety of disciplines, may be established under appropriate supervision.

4. STAFF TRAINING AND QUALIFICATIONS

4.1 Initial

- Medical, nursing and other staff should have training and ability to work with the alcoholic/drug abuse patient and be able to liaise with other hospital staff and community agencies.
- Staff must meet provincial registration or licensing standards.
- A core knowledge program[1] in the addictions field should be offered to all staff significantly involved in in-patient addiction services.

4.2 Continuing

Opportunities should be provided for upgrading the knowledge and enhancing positive attitudes of all hospital staff involved with any aspect of in-hospital treatment services. This could serve as an important influence on staff contribution to community education and health promotion services.

5. SPECIFIC SUPPORTING DEPARTMENTS AND SERVICES

Included, when available, would be:

- chaplaincy
- laboratory and radiology

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1. National Planning Committee on Training, Core Knowledge in the Drug Field - A Basic Manual for Trainers, Health Promotion Directorate, Health Services and Promotion Branch, Health and Welfare Canada, 1978. (Series of 12 booklets).

- medical and surgical consultation
- neurological
- nutrition
- occupational therapy
- pharmacy
- psychiatry
- psychology
- recreational therapy
- social services

6. SPACE ALLOCATION AND UTILIZATION

If there is a unit dedicated for this specific program, requirements would be dependent upon the patient load for space and bed allocation and utilization specific to the functional needs of the program. This would be similar in size to a standard general in-patient unit.

7. EQUIPMENT AND MATERIALS

Where a unit is established, the equipment would be dependent on the functional needs of the program. Generally, equipment required would be similar to that for a general in-patient unit.

8. RELATIONSHIP TO OTHER DEPARTMENTS AND SERVICES

There should be ready access to:

- detoxification units
- formal alcohol/drug abuse programs
- community services

III OUT-PATIENT SERVICES

IV AFTERCARE SERVICES

V EDUCATION AND HEALTH PROMOTION SERVICES

Note regarding III, IV and V above:

It is acknowledged that out-patient services may be hospital-based, as an extension of a residential (in-patient) treatment program, and that aftercare services and education and health promotion services less often might have such a hospital affiliation. However, it is not felt that useful guidelines can be presented, at this time, because of the great diversity of organization, scope and type of services that may be valid in these areas.

APPENDIX I

CANADIAN ALCOHOL AND DRUG DEPENDENCY COMMISSIONS

NEWFOUNDLAND:

Executive Director
Newfoundland Alcohol & Drug Commission
139 Water Street
5th Floor, Royal Trust Building
ST. JOHN'S, Newfoundland
A1C 1B1

PRINCE EDWARD ISLAND:

Director of Addiction Services
P.O. Box 37
University Avenue
CHARLOTTETOWN, P.E.I.
C1A 7K2

NOVA SCOTIA:

Executive Director
Nova Scotia Commission on Drug Dependency
5675 Spring Garden Road, Suite 314
HALIFAX, Nova Scotia
B3J 1H1

NEW BRUNSWICK:

Executive Director
New Brunswick Alcoholism & Drug Dependency Commission
P.O. Box 6000
103 Church Street
FREDERICTON, New Brunswick
E3B 5H1

ONTARIO:

President
Addiction Research Foundation of Ontario
33 Russell Street
TORONTO, Ontario
M5S 2S1

MANITOBA:

Executive Director
Alcoholism Foundation of Manitoba
1031 Portage Avenue
WINNIPEG, Manitoba
R3G 0R9

SASKATCHEWAN:

Executive Director
Alcoholism Commission of Saskatchewan
3475 Albert Street
REGINA, Saskatchewan
S4S 6X6

ALBERTA:

Executive Director
Alberta Alcoholism & Drug Abuse Commission
6th Floor
Pacific Plaza building
10909 Jasper Avenue
EDMONTON, Alberta
T5J 3M9

BRITISH COLUMBIA:

Executive Director
Alcohol and Drug Programs
Ministry of Health
Suite 202
1755 West Broadway
VANCOUVER, British Columbia
V6J 4S5

NORTHWEST TERRITORIES:

Coordinator
Alcohol and Drug Program
Department of Health & Social Services
P.O. Box 1769
YELLOWKNIFE, N.W.T.
X1A 2L9

YUKON:

Director of Regional Services
Alcohol and Drug Services
Department of Health & Human Resources
Government of Yukon
P.O. Box 2703
WHITEHORSE, Yukon
Y1A 2C6

APPENDIX II

GUIDELINES FOR POLICIES AND PROCEDURES FOR SPECIAL SERVICES IN HOSPITALS

Guidelines for policies and procedures for special services in hospitals were formulated after a review of provincial, national and international information.

It is hoped that the following outline will serve as a guide for the development of more comprehensive and specific Special Services policies in order to ensure the most effective and efficient delivery of patient care.

I ROLE AND OBJECTIVES

- Philosophy and objectives of the service
- Type of patients served
- By diagnosis and/or severity of illness
- Restriction of service, if any
- Services provided

II ORGANIZATION OF SERVICE

- Governing Board responsibility
- Relationship to Administrator and Medical Staff
- Service management

(i) Specific responsibilities of staff

- Medical Director
- Other medical staff
- Nursing Staff
- Other Staff

(ii) Committees

- Membership to be defined by discipline and number
- Terms of reference to be defined
- Provision for consultation with appropriate hospital and medical staff
- Schedules for formal and ad hoc meetings

III POLICIES FOR OPERATION OF SERVICE

1. General

- Admission authority (Identification of individual(s) who have authority to admit)
- Admission priorities:
  - Diagnostic category
  - Clinical condition
- Routine admission Standing Orders
- Medical Orders
- Emergency admission Standing Orders
- Length of stay by diagnosis
- Infection control and isolation
- Patient records, reports and charting
- Handling of emergency situations including C.P.R.
- Emergency delegation of responsibility to medical, nursing and/or other staff
- Research/clinical investigation

- Palliative care, determination of death, authorization for autopsies, handling of bodies

- Referral, consultation (mandatory and other), transfer, follow-up

2. Staff

- Selection criteria: education, experience, interests

- Criteria for granting medical/clinical privileges

- Medical coverage/Staff coverage of service

- Delineation of student and supervisor roles including responsibility, authority and accountability

- Position descriptions

- Orientation and continuing education

- Performance evaluation

- Volunteers

3. Patient

- Patient's rights

- Patient identification

- Family participation

- Confidentiality

- Patient/family education

- Patient valuables, assets and belongings

- Consent for treatment

- Visiting privileges

4. Safety

- Safety and accident prevention
- Reporting of accidents and incidents
- Equipment maintenance and safety
- Fire and disaster plan
- Use of restraints

5. Quality Assurance

- Practice standards
- Continuing evaluation of effectiveness of service
- Patient status assessment on admission and discharge
- Incident reports
- Patient care review
- Infection control
- Audits: medical and nursing care, concurrent and retrospective
- Peer review
- Morbidity/mortality review
- Employee performance appraisal
- Product and equipment use and evaluation

IV PROCEDURES

- Elective procedures
- Emergency alert system procedures
- Medical records and statistical procedures
- Policy and procedure manuals

APPENDIX III

GUIDELINES FOR SPECIAL SERVICES IN HOSPITALS

The following guidelines have been prepared by the federal-provincial Sub-Committee on Special Services in Hospitals. These guidelines were requested by the Federal-Provincial Advisory Committee on Institutional and Medical Care services. Some of the guidelines are updated versions of guidelines previously published by the Sub-Committee.

Addiction Services in Hospitals
Adult Psychiatric Services Provided by General Hospitals
Burn Unit
Cardiovascular Services in Hospitals
- Ambulatory Electrocardiography Monitoring
- Cardiac Care
- Cardiac Catheterization
- Cardiac Surgery
- Cardiovascular Nuclear Medicine
- Cardiac Pacemaker
- Cardiac Stress Testing
- Echocardiography
- Intermediate Cardiac Care
- Non-Invasive Vascular Laboratories
- Phonocardiography

Child and Adolescent Psychiatric Services Provided by General Hospitals
Child and Adolescent Services in General Hospitals
Computed Tomography
Day Surgery Unit
Dental Care Units in Hospitals
Diabetic Day Care Unit
Diagnostic Ultrasound Facilities in Hospitals
Emergency Services in Hospitals
Geriatric Day Hospitals
Geriatric Unit in a Hospital
Intensive Care Unit
Long Term Adult Institutional Care
Nuclear Medicine in Hospitals
Palliative Care Services in Hospitals

Patient Hostel Unit
Perinatal Intensive Care Unit
Regional Renal Failure Program
Rehabilitation Medicine Unit
Respiratory Technology Service/Unit
Spinal Cord Injury Unit
Stroke Services